

Date filed: \_\_\_\_\_

File no.: \_\_\_\_\_

**STATEMENT OF CLAIM  
TO  
TRUSTEES OF THE LAWYERS' FUND FOR CLIENT PROTECTION  
OF THE BAR OF DELAWARE**

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**INSTRUCTIONS**

- **Answer every question. If space is inadequate, attach additional pages.**
  - **Submit copies of canceled checks, receipts, letters, etc. that will support your claim.**
  - **Your claim must be notarized.**
  - **Mail your completed claim to: Lawyers' Fund for Client Protection, 820 N. French Street, 11th Floor, Wilmington, DE 19801.**
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1. Your name: \_\_\_\_\_
2. Your address: \_\_\_\_\_
3. Your daytime telephone number: \_\_\_\_\_
4. Name of lawyer being complained about: \_\_\_\_\_
5. Address of that lawyer: \_\_\_\_\_
6. How much money do you claim you lost? \_\_\_\_\_
7. State the date the loss occurred: \_\_\_\_\_
8. State the date when you discovered the loss: \_\_\_\_\_
9. What do you claim the lawyer did wrong? \_\_\_\_\_

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**10. Additional information about the claim may be obtained from the following:**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Tel. No.: \_\_\_\_\_ Tel. No.: \_\_\_\_\_

LAWYERS' FUND FOR CLIENT PROTECTION

**11.** Have you recovered any of the money you claim to have lost? \_\_\_\_\_

If so, state the amount you recovered, when you recovered it and from whom you recovered it.

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**12.** Have you filed a lawsuit or obtained a judgment against the lawyer or anyone else with respect to the money you claim to have lost? \_\_\_\_\_

If so, state the name of the lawsuit, the date it was filed, the court in which it was filed, and the date of the judgment, if any.

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**13.** Are you personally related to the lawyer being complained about or are you/were you a business associate or employee of that lawyer? \_\_\_\_\_

If so, describe your relationship to the lawyer.

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**14.** Name, address and telephone number of lawyer, if any, who represents you for this claim:

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**NOTE: No lawyer is permitted to charge you a fee for assisting in the preparation or resolution of this claim.**

LAWYERS' FUND FOR CLIENT PROTECTION

**NOTICE TO CLAIMANT:** By signing this claim form, you indicate that you understand that the Lawyers' Fund for Client Protection has no legal responsibility for the acts of individual lawyers in their practice of law, that the decision of the Trustees of the Lawyers' Fund for Client Protection to pay anything to you on account of your claim is entirely within their own judgment and is not a matter of your right, and that neither you nor anyone else has the right to sue the lawyers' Fund for Client Protection or its Trustees on account of your claim.

STATE OF DELAWARE

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: SS

**AFFIDAVIT**

COUNTY OF \_\_\_\_\_

:

\_\_\_\_\_ swears under oath (or affirms) that (s)he is the person who has the claim described in this Statement of Claim, that (s)he has read and understands the Statement of Claim and believes that the information contained in the Statement of Claim is true to the best of his(her) own knowledge, that (s)he agrees to cooperate in the investigation of this claim and also in any disciplinary proceedings against the lawyer complained about, and that if the Trustees decide on any payment of this claim, (s)he agrees to sign any appropriate documents that the Trustees may require.

\_\_\_\_\_  
(Signature of Claimant)

Signed and sworn to (or affirmed) before me on

\_\_\_\_\_  
(Date)

by

\_\_\_\_\_  
(Name of Claimant)

\_\_\_\_\_  
(Signature of Notarial Officer)

\_\_\_\_\_  
(Title of Notarial Officer)

My commission expires \_\_\_\_\_